



280050

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

65 26640

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) AGNES MINNETT BEAVER			2a. DATE OF DEATH MONTH DAY YEAR September 30, 1985		2b. HOUR 7:57A.	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 15, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD.		
10. CITY OR TOWN OF DEATH Leonardtwn	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY St. Mary's	13c. CITY OR TOWN Oakley	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Bernard MaQuire Hall		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl P. Bailey				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS Kelso F. Beaver Same as 13e.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Acute Myocardial Infarction. DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE 				22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) N. Shah, M.D.				22e. ADDRESS Leonardtwn, Md, 20650		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/3/85		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cem.		
23d. LOCATION CITY OR TOWN COUNTY STATE Bushwood St. Mary's Md.		25a. DATE REC'D. BY REGISTRAR OCT 2 1985				
24. FUNERAL DIRECTOR NAME ADDRESS W. Clarke Mattingley, Leonardtown, Md.				25b. REGISTRAR'S SIGNATURE 		

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1102 COLTON 2011

274012

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND									
DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
REG. NO. 8 5 2 6 6 4 1									
1. FOR STATE REGISTRAR					2a. DATE OF DEATH				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
Lee Dewey Davis					9-13-85 10 PM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		White		1 3 42		42 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Washington, D.C.		USA				St Mary's MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Lexington Park		Amherst House							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13e. STREET ADDRESS / ZIP CODE			
Md.		SMC		Leonardtown		Rt 1 Box 13F 20650			
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
Lee Dewey Davis					Mamie Saunders				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, (COLOR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.				
17. INFORMANT					ADDRESS				
NKH Dewey L. Davis					60-56 Boughton Hill Rd. Victor, NY.				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND	
IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u>								14-564	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cancer of the Pancreas</u>								How long	
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f. LOCATION CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1984, 19, to 9/13/85, 19, that (I) (we) last saw the deceased alive on 9/12/85, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE					DEGREE			22c. DATE SIGNED	
William D. Boyd					ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			9/16/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
William D. Boyd 11, M.D.					Leonardtown, Maryland				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
CREMATION		9-18-85		CEDAR HILL CREMATORY		SUITLAND PG MD			
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE				
W. Clarke Mattingly					SEP 20 1985				

THE AMERICAN
COUNCIL ON EDUCATION
WASHINGTON, D.C.

WHITE
COTTON
FIBER

FOR COTTON FIBER



AMERICAN COUNCIL ON EDUCATION
WASHINGTON, D.C.

280009

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

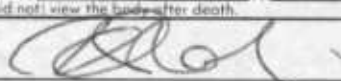
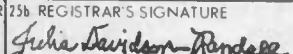
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DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										5 2 6 6 4 2	
1. FOR STATE REGISTRAR										REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) GAYLORD HILL DAY					2a DATE OF DEATH MONTH DAY YEAR September 29, 1985			2b HOUR 10:20^{AM}			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR April 20, 1910		6 AGE (IN YEARS LAST BIRTHDAY) 75		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD.					
10 CITY OR TOWN OF DEATH Leonardtown		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
13a STATE Maryland		13b COUNTY St Mary's		13c CITY OR TOWN Hollywood		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE P.O.Box 67 Brink Cottage			
14 FATHER'S NAME FIRST MIDDLE LAST Lester Wiggins Day					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria Landsky						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 11		17 INFORMANT ADDRESS Lizette T. Day same as #13 above							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiorespiratory Arrest. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Pneumonia, Hydrocephalus											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE 						DEGREE			22c DATE SIGNED		
22d PHYSICIAN'S NAME (TYPE OR PRINT) N. Shah, M.D.						22e ADDRESS Leonardtown, Maryland 20650					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b DATE 9/30/1985			23c NAME OF CEMETERY OR CREMATORY Cedar Hill			23d LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G., Maryland		
24 FUNERAL DIRECTOR NAME W. Clarke Mattingley						24b ADDRESS Leonardtown, Maryland			25a DATE REC'D. BY REGISTRAR OCT 2 1985		
						25b REGISTRAR'S SIGNATURE 					

280003

October 29, 1955 10:30

of the County



Int'l. Reg. in Hospital

Reimbursement



Reimbursement, Maryland 20550

W. H. H. H.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

5 2 6 6 4 3

1. DECEASED NAME (TYPE OR PRINT) Francis E Edelen			2a. DATE OF DEATH MONTH 9 DAY 19 YEAR 85		2b. HOUR 1:50 PM
3. SEX M	4. RACE Black	5. DATE OF BIRTH MONTH 01 DAY 10 YEAR 97		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD.	
10. CITY OR TOWN OF DEATH Lexington PK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Amber House Nsg Facilities		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farm Laborer		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE md			13b. COUNTY Charles	13c. CITY OR TOWN Hughesville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST un Known MIDDLE un Known LAST un Known			15. MOTHER'S MAIDEN NAME FIRST un Known MIDDLE un Known LAST un Known		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214 18 8676		17. INFORMANT ADDRESS Rt. 1 Box 91 Francis Edelen, Jr. Aquasco, Md. 20618	
18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Possible Myocardial Infarct DUE TO, OR AS A CONSEQUENCE OF (b) ASCD DUE TO, OR AS A CONSEQUENCE OF (c) ASCD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sec.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/13/84 19____, to 9/19/85 19____, that (I) (we) last saw the deceased alive on 9/12/85 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Wm Boyd		DEGREE		22c. DATE SIGNED 9/19/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Boyd, Wm		22e. ADDRESS Leonard Rumm, MD,			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 23 Sept 85	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Ch. Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Bryantown Chas. Md.	
24. FUNERAL DIRECTOR NAME Marcell Adams ADDRESS Aquasco, Md. 20608		25. DATE RECEIVED BY REGISTRAR (TYPE OR PRINT) SEP 30 1985			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

578131



252160

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

5 2 6 6 4 4

1. DECEASED NAME (TYPE OR PRINT) Sophie Mattingly Gough			2a. DATE OF DEATH MONTH DAY YEAR September 2, 1985			2b. HOUR M				
3 SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 8, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD.				
10. CITY OR TOWN OF DEATH Leonardtown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.					13b. COUNTY St. Mary's		13c. CITY OR TOWN Leonardtown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James F. Mattingly					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hortense Hayden					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-16-4520		17. INFORMANT ADDRESS James M. Gough, Jr. Same as 13e.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Aneurysm</u> DUE TO OR AS A CONSEQUENCE OF (b) <u>Cardiovascular event</u> DUE TO OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minute</u> <u>4 1/2 h</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) —						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE —		21g. I certify that (I) (this hospital) attended the deceased from <u>8/31/85</u> to <u>9/2/85</u> , that (I) (last saw the deceased alive on <u>8/31/85</u> , and that in (my) (last) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death.				
22a. SIGNATURE OF PHYSICIAN <u>David Mossman</u>					22b. ADDRESS Mechanicsville, Md. 20659			22c. DATE SIGNED 9/4/85		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/5/85		23c. NAME OF CEMETERY OR CREMATORY Our Lady's Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Medley's Neck St. Mary's Md				
24. FUNERAL DIRECTOR W. Clarke Mattingley, Leonardtown, Md.					25a. DATE REC'D. BY REGISTRAR SEP 5 1985		25b. REGISTRAR'S SIGNATURE <u>John H. ...</u>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and cemetery filled in, page 3 should be detached for use on the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

51510

CHIEF MARSHAL

RECEIVED 2010 2010

[Faint, illegible text and markings, possibly bleed-through from the reverse side of the page.]

274067

FOR
1. STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 2 6 6 4 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Rose Bernadette Grace			2a. DATE OF DEATH MONTH DAY YEAR Sept. 24, 1985		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 15, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash., D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD.		
10. CITY OR TOWN OF DEATH Leonardtwn	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY St. Mary's	13c. CITY OR TOWN Mechanicsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ? ? ?		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ? ? ?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-28-6600T		17. INFORMANT Edith L. Lambert Same as 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung Cancer DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/23/85 to 9/24/85, that (I) (we) lost saw the deceased alive on 9/23/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) witness his/her death.					
22b. SIGNATURE Wm D. Boyd		DEGREE		22c. DATE SIGNED 9/25/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm D. Boyd		22e. ADDRESS Leonardtwn MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/27/85		23c. NAME OF CEMETERY OR CREMATORY Charles Memorial Gardens	
23d. LOCATION CITY OR TOWN COUNTY STATE Leonardtwn St. Mary's Md.		24. FUNERAL DIRECTOR NAME W. Clarke Mattingley ADDRESS Leonardtown, Md			
25a. DATE REC'D. BY REGISTRAR SEP 27 1985		25b. REGISTRAR'S SIGNATURE John Davidson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 of this certificate should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, record cause of death on page 2, and file in nonfatal section.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) MARY Natalie Pirrami GRAY					2a. DATE OF DEATH MONTH DAY YEAR XXXXXX Sept. 1, 1985			2b. HOUR 2:30 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 25, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minnesota		7b. CITIZEN OF WHAT COUNTRY? USA		8. unknown MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD.			
10. CITY OR TOWN OF DEATH Lexington Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Amber House Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Drug store clerk		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE CITY COUNTY Maryland Calvert North Beach					13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS / ZIP CODE Westlawn Inn 20714		
14. FATHER'S NAME FIRST MIDDLE LAST unknown					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-48-7281		17. INFORMANT ADDRESS Calvert Co., Md. Calvert County Social Services					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Cancer (Breast) to Brain and lung</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>0</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>8/27</u> 19 <u>85</u> , to <u>9/1</u> 19 <u>85</u> , that (we) lost saw the deceased alive on above (1) (we) did not view the body after death.									
22b. SIGNATURE <u>David Allen, M.D.</u> DEGREE <u>MD</u>					22c. DATE SIGNED <u>9/3/85</u>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) Leonardtwn, Maryland 20650	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory Suitland		23d. LOCATION CITY OR TOWN COUNTY STATE P.G. Md.			
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley Leonardtown, Md.					25a. DATE REC'D. BY REGISTRAR SEP 11 1985		25b. REGISTRAR'S SIGNATURE <u>Gina Davidson</u>		

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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REG. NO.

MEDICAL CERTIFICATION

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

5 2 6 6 4 8

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST AGNES ELIZABETH HAMMETT			MONTH DAY YEAR September 20, 1985			6:30AM		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE		7. UNDER 1 YEAR		
Female	White	MONTH DAY YEAR Jan. 9, 1907		78 YRS		MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9b. CITIZEN OF WHAT COUNTRY?	9. BALTIMORE CITY OR COUNTY OF DEATH						
Washington, D.C.	USA	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		St. Mary's County MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Leonardtwn	St. Mary's Hospital			Home maker				
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			
Maryland			St Mary's	Ridge	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET ADDRESS / ZIP CODE		
FIRST MIDDLE LAST William Albert Stone			FIRST MIDDLE LAST Mary Elizabeth Peacock			Gen. Del. 20680		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No			212 74 8525		Robert L. Hammett P.O. Box 94 Avenue, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cardiac Respiratory Failure</u>								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								
(b) <u>Carcinoma of Breast</u>								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a								
<u>Metastatic to Lung & Pleural Effusion</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
<u>A. Patil</u>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
A. Patil, M.D.			Leonardtwn, Md. 20650					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial			Sept. 23, 1985		St Michael Cem.		Ridge St. Mary's, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
W. Clarke Mattingley Leonardtown, Maryland					SEP 24 1985		<u>Gulia Davidson-Ronde</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be received within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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St. Mary's County

St. Mary's County

St. Mary's County

St. Mary's County

St. Mary's County

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH2 6 6 4 9
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR		2b. HOUR	
Mabel Chapter Herbold								Sept. 9, 1985		6:40 PM			
1. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Female	White	Jan. 25, 1898		87 YRS.						19		M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
New York		U.S.A.				St. Mary's County MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Patuxent River		Pax River Naval Hospital		Homemaker									
13a. STATE		13b. CITY OR TOWN		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		St. Mary's		Lexington Park		<input type="checkbox"/> NO <input type="checkbox"/>		Rt. 1 Box 8657		20653			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
William Chapter		Katherine Mower											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No		578-36-9221		George F. Herbold		Same as 13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
				Probable Aspiration Pneumonia				H.N.					
				(b)		DUE TO, OR AS A CONSEQUENCE OF							
				(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED									
Wm D. Boylston		M.D. Dpt		9/10/85									
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS											
Wm D. Boylston		Cedar Hill Crematory											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Cremation		9/11/85		Cedar Hill Crematory		Suitland P.G. Md.							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
W. Clarke Mattingley		Leonardtwn, Md.		SEP 13 1985		John Davidson							

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FOR A PAGE 5. REMAIN PAGE 5 FOR YOUR FILES TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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WILLIAM WILSON

2002 COLLECTOR



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 5 2 6 6 5 0							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET POWELL HIDALGO					2a. DATE OF DEATH MONTH DAY YEAR 09/27/85			2b. HOUR 1500M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 13, 1936		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Orange, Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD			
10. CITY OR TOWN OF DEATH Patuxent River		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Naval Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY St. Mary's		13c. CITY OR TOWN Lexington Park		13d. INSIDE CITY LIMITS? NO <input type="checkbox"/>		13e. STREET ADDRESS 510 Hancock Road	
14. FATHER'S NAME FIRST MIDDLE LAST Elejah Lloyd Powell					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Lloyd				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 215-34-7018		17. INFORMANT Allan S. Hidalgo			ADDRESS Same as 13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC SMALL CELL CARCINOMA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE C.W. Page				DEGREE M ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/27/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/2/85		23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE California St. Marys Md.			
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley				ADDRESS Leonardtwn, Md.		25a. DATE REC'D. BY REGISTRAR SEP 30 1985		25b. REGISTRAR'S SIGNATURE Gina Davidson	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 5 2 6 6 5 1			
1 DECEASED NAME (TYPE OR PRINT) James Lancaster Holly				2a DATE OF DEATH MONTH DAY YEAR September 18, 1985				2b HOUR M			
3 SEX Male		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR Sept. 28, 1903		6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7a UNDER 1 YEAR MONTHS DAYS		7b UNDER 24 HRS HOURS MIN.	
7c BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7d CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD.					
10 CITY OR TOWN OF DEATH Callaway		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Home (Redman Rd.)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) XXX Farmer		12b KIND OF BUSINESS OR INDUSTRY Farm			
13a STATE Md.		13b COUNTY St. Mary's		13c CITY OR TOWN Clements		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS Rt. 234		20624	
14 FATHER'S NAME FIRST MIDDLE LAST John F. Holly				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Forrest							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES)		16b SOCIAL SECURITY NO 214-30-0659		17 INFORMANT ADDRESS Forrest Holly Gen. del. Clements, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Probable Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18a											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from 8-6-1985 to 9/19/85, that (I) (we) lost saw the deceased alive on 8-6-1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Wm. B. L.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 9/19/85			
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 9/21/85		23c NAME OF CEMETERY OR CREMATORY Charles Mem. Gdns.		23d LOCATION CITY OR TOWN COUNTY STATE Leonardtown, St. Mary's Md.					
24 FUNERAL DIRECTOR NAME W. Clarke Mattingley				ADDRESS Leonardtown, Md.		25a DATE REC'D. BY REGISTRAR SEP 23 1985		25b REGISTRAR'S SIGNATURE Julia Davidson-Rendall			

BP

110575

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DIVISION OF VITAL RECORDS, 201 W. PESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										2 6 6 5 2 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) LOUIS MORGAN MARVIN JENKINS										2a. DATE KNOWN OF DEATH ESTIMATED X 9/ 30 19 85	
3. SEX Male		4. RACE White		5. DATE OF BIRTH (MONTH DAY YEAR) Feb. 15, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD Sept. 30, 19 85	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Northumber, Va.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH St Mary's MD		
10. CITY OR TOWN OF DEATH Patuxent River			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Naval Air Station Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Virginia			13b. COUNTY Northumber		13c. CITY OR TOWN Lewisetta		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Box 33 22505		
14. FATHER'S NAME (FIRST MIDDLE LAST) Warren Aderson Jenkins						15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Ada Elizabeth Pillsbury					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 230 12 4534		17. INFORMANT ADDRESS Shirley S. Jenkins same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sec	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY (HOUR A.M. MONTH DAY YEAR) P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21i. LOCATION (STREET CITY OR TOWN COUNTY STATE)					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>William D. Boyd ll</u>				TITLE (SPECIFY) <u>M.D.</u>				MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT) William D. Boyd ll, M.D.				ADDRESS Leonardtwn, Maryland							
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial				23b. DATE 10/4/1985		23c. NAME OF CEMETERY OR CREMATORY Melrose Cemetery			23d. LOCATION (STREET CITY OR TOWN COUNTY STATE) Lottsburg, Virginia		
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley						ADDRESS Leonardtwn, Maryland					
25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE <u>John L. ...</u>					

280143

93811 HOTTON ROAD

CHIEF MAN DOWD



THE CHIEF MAN DOWD

W. J. F. M. 1912

253077

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

5 2 6 6 5 3

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BARBARA ELOISE JOHNSON			2a. DATE OF DEATH MONTH DAY YEAR September 4, 1985		2b. HOUR 4:05a.m.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 2, 1927		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 58	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Coltons Point	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD.	
10. CITY OR TOWN OF DEATH Leonardtown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LPN		12b. KIND OF BUSINESS OR INDUSTRY Nursing
13a. STATE Md.		13b. COUNTY St. Mary's	13c. CITY OR TOWN Coltons Point	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Gen. Del 20626
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Carroll Gass			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella May Cullins		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216-22-3603		17. INFORMANT ADDRESS Wm. C. Johnson Avenue, Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic Shock & Cardiac Failure DUE TO, OR AS A CONSEQUENCE OF (b) Urinary Tract Infection DUE TO, OR AS A CONSEQUENCE OF (c) Uncontrolled Diabetes Mellitus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hours 2 days
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PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Uncontrolled Diabetes Mellitus**

19a. DATE OF OPERATION -	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from 9/3 , 19 85 , to 9/4 , 19 85 , that (we) lost saw the deceased alive on 9/4 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.			
22b. SIGNATURE David Allen		DEGREE M.D.	22c. DATE SIGNED 9/4/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David Allen, M.D.		22e. ADDRESS Leonardtown, Md. 20650	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9/6/85	23c. NAME OF CEMETERY OR CREMATORY Charles Memorial Gdns.	23d. LOCATION CITY OR TOWN COUNTY STATE Leonardtown, St. Mary's Md.
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley, Leonardtown, Md.		25a. DATE REC'D. BY REGISTRAR SEP 6 1985	25b. REGISTRAR'S SIGNATURE Alia Tindall-Randall

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1:02

September 1, 1988

RECEIVED

MAINE

SEP 1 1988

St. Mary's County

St. Mary's Hospital

Georgetown

Dr. [illegible]



[Faint, mostly illegible handwritten text, possibly a medical note or prescription.]

003000, 00-000000

David Allen, M.D.

268048

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 6 6 5 4
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ronel		FIRST		MIDDLE		LAST Largent		2a. DATE KNOWN OF DEATH ESTIMATED Sept. 17, 1985		MONTH		DAY		YEAR		2b. HOUR M	
1. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 6, 1941		6. AGE (IN YEARS) LAST BIRTHDAY 43 YRS		IF UNDER 1 YR. MONTHS DAYS 19		IF UNDER 24 HRS. HOURS MIN. 19		7c. DATE PRONOUNCED DEAD 19		MONTH DAY YEAR		2d. HOUR M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County					
10. CITY OR TOWN OF DEATH Leonardtwn				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck driver				12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland		13b. COUNTY St. Mary's		13c. CITY OR TOWN Mechanicsville		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS Rt. 3 Box 63		20659							
14. FATHER'S NAME FIRST MIDDLE LAST Daniel Largent				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha ?													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 213-40-9647				17. INFORMANT Betty Largent				ADDRESS Same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sec.																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE Wm D Boyd II				TITLE (SPECIFY) DPT				MEDICAL EXAMINER				DATE SIGNED 9/19/85					
EXAMINER'S NAME (TYPE OR PRINT) Wm D Boyd II				ADDRESS LEONARDTOWN, MD													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 9/20/85				23c. NAME OF CEMETERY OR CREMATORY Charles Memorial Gardens				23d. LOCATION CITY OR TOWN COUNTY STATE Leonardtwn St. Mary's Md					
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley				ADDRESS Leonardtwn, Md				25a. DATE REC'D. BY REGISTRAR SEP 23 1985				25b. REGISTRAR'S SIGNATURE J. A. Swider					



UNIVERSITY OF
BETHLEHEM

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259155

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 of 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				5 2 6 6 5 5			
1- FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSA BELL LOFTIS				2a DATE OF DEATH MONTH DAY YEAR September 10, 1985		2b HOUR 12:00 P.M.	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Feb. 14, 1893		6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 92 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NC		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD.	
10 CITY OR TOWN OF DEATH Leonardtwn		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE MD.		13b COUNTY St. Mary's		13c CITY OR TOWN California		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Bill Carey		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Loftis		13e STREET ADDRESS / ZIP CODE Star Route Box 15 20619			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b SOCIAL SECURITY NO. 579-09-6161		17 INFORMANT D Rose Lynch		ADDRESS California, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Senile Dementia Cardiac Arrhythmias							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 9/12 19 85 to 9/10 19 85 , that (I) (we) (we) last saw the deceased alive on 9/10 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE David C. Allen				DEGREE MD		22c. DATE SIGNED 9/11/85	
22d PHYSICIAN'S NAME (TYPE OR PRINT) David Allen, M.D.				22e ADDRESS Leonardtwn, Md. 20650			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 9/13/85		23c NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Arlington, Arlington VA	
24 FUNERAL DIRECTOR W. Clarke Mattingley, Leonardtown, Md.				25a DATE REC'D. BY REGISTRAR SEP 13 1985		25b REGISTRAR'S SIGNATURE Lelia Davidson-Randall	

BP

223132

September 10, 1952

St. Mary's County

St. Mary's County

St. Mary's County



St. Mary's County

St. Mary's County

252137

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, and 3. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

5 2 6 0 5 0

1. DECEASED NAME (TYPE OR PRINT) Beatrice Palmer McGuire			2a. DATE OF DEATH MONTH DAY YEAR 09-03-85		2b. HOUR 140Am M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 04 18 00	6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Chicago, Illinois	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD		
10. CITY OR TOWN OF DEATH Leonardtown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant	12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland	13b. COUNTY St. Mary's	13c. CITY OR TOWN Mechanicsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS General Delivery, Mechanicsville 20650 MD	
4. FATHER'S NAME FIRST MIDDLE LAST U. Lee McGuire		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennifer Ching			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-20-3631		17. INFORMANT ADDRESS Rt. 1, Box 259 Hughesville, Md. 20637 Juanita Connick	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma - gastroenteric</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Diabetes mellitus, dementia, atherosclerosis</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 1985</u> to <u>Sept 3 1985</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did) not view the body after death.					
22b. SIGNATURE <u>J. Roy Guyther, M.D.</u>		DEGREE		22c. DATE SIGNED 9-3-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Roy Guyther, M.D.		22e. ADDRESS Mechanicsville, Md. 20650			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/5/85		23c. NAME OF CEMETERY OR CREMATORY Christ Church Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Chaptico St. Mary's Md.					
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley, Leonardtown, Md.		25a. DATE REC'D. BY REGISTRAR SEP 5 1985		25b. REGISTRAR'S SIGNATURE Tina Davidson-Randall	

BP

1. The first part of the document is a list of names and addresses of persons who have been in contact with the subject of this document. The names are listed in alphabetical order. The addresses are listed in the order in which they were received. The names and addresses are as follows:

Name	Address
Mr. J. Edgar Hoover	Washington, D. C.
Mr. Clegg	Washington, D. C.
Mr. Glavin	Washington, D. C.
Mr. Ladd	Washington, D. C.
Mr. Nichols	Washington, D. C.
Mr. Rosen	Washington, D. C.
Mr. Tracy	Washington, D. C.
Mr. Carson	Washington, D. C.
Mr. Egan	Washington, D. C.
Mr. Gurnea	Washington, D. C.
Mr. Hendon	Washington, D. C.
Mr. Pennington	Washington, D. C.
Mr. Quinn	Washington, D. C.
Mr. Nease	Washington, D. C.
Mr. Gandy	Washington, D. C.
Mr. Egan	Washington, D. C.
Mr. Gurnea	Washington, D. C.
Mr. Hendon	Washington, D. C.
Mr. Pennington	Washington, D. C.
Mr. Quinn	Washington, D. C.
Mr. Nease	Washington, D. C.
Mr. Gandy	Washington, D. C.

1

2. The second part of the document is a list of names and addresses of persons who have been in contact with the subject of this document. The names are listed in alphabetical order. The addresses are listed in the order in which they were received. The names and addresses are as follows:

Name	Address
Mr. J. Edgar Hoover	Washington, D. C.
Mr. Clegg	Washington, D. C.
Mr. Glavin	Washington, D. C.
Mr. Ladd	Washington, D. C.
Mr. Nichols	Washington, D. C.
Mr. Rosen	Washington, D. C.
Mr. Tracy	Washington, D. C.
Mr. Carson	Washington, D. C.
Mr. Egan	Washington, D. C.
Mr. Gurnea	Washington, D. C.
Mr. Hendon	Washington, D. C.
Mr. Pennington	Washington, D. C.
Mr. Quinn	Washington, D. C.
Mr. Nease	Washington, D. C.
Mr. Gandy	Washington, D. C.
Mr. Egan	Washington, D. C.
Mr. Gurnea	Washington, D. C.
Mr. Hendon	Washington, D. C.
Mr. Pennington	Washington, D. C.
Mr. Quinn	Washington, D. C.
Mr. Nease	Washington, D. C.
Mr. Gandy	Washington, D. C.

266052

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
 BP _____
 DHMH - 17
 (VR A15 ME (5))
1- FOR
STATE
REGISTRAR
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

 8 5 2 6 6 5 7
 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HARRY WILBERT MILLER			2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH DAY YEAR Sept. 11 1985		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 10, 1915	6. AGE (IN YEARS) LAST BIRTHDAY 70 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. CITY OR TOWN OF DEATH Leonardtwn		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Star Route Box 76	
12b. KIND OF BUSINESS OR INDUSTRY					
13. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's MD.					
14. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Md.	13b. COUNTY St. Mary's	13c. CITY OR TOWN Chaptico	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Star Route Box 76	
14. FATHER'S NAME FIRST MIDDLE LAST George Washington Miller			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Mills		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 179-14-6264		17. INFORMANT ADDRESS Teresa C. Miller Same as 13e.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>[Signature]</i>		TITLE (SPECIFY) M.D.		DATE SIGNED 9/13/85	
EXAMINER'S NAME (TYPE OR PRINT) JAMES C. BOYD M.D.		ADDRESS Leonardtwn, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9/13/85	23c. NAME OF CEMETERY OR CREMATORY Charles Memorial Gdns.		23d. LOCATION CITY OR TOWN COUNTY STATE Leonardtwn, St. Mary's	
24. FUNERAL DIRECTOR NAME ADDRESS W. Clarke Mattingley, Leonardtwn, Md.		25a. DATE REC'D. BY REGISTRAR SEP 19 1985		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> MD.	

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269096

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH2 6 6 5 8
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
ALFRED nmn MORGAN			9/22, 1985			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. DATE OF DEATH	10. MONTH	11. DAY
Male	White	June 4, 1914	71 YRS.			Sept. 22,	19	85
12. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	13. CITIZEN OF WHAT COUNTRY?	14. MARRIED	15. NEVER MARRIED	16. WIDOWED	17. DIVORCED	18. BALTIMORE CITY OR COUNTY OF DEATH		
Helen, Md.	USA	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	St Mary's		
19. CITY OR TOWN OF DEATH	20. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	21. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		22. KIND OF BUSINESS OR INDUSTRY				
Mechanicsville	Rt. 4 Box 366 at home	Farming		Self				
23. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			24. STATE			25. COUNTY		
Maryland			St Mary's			Mechanicsville		
26. FATHER'S NAME			27. MOTHER'S MAIDEN NAME			28. ADDRESS		
William Douglas Morgan			Ida Russell			Rt. 4, Box 366		
29. WAS DECEASED EVER IN U.S. ARMED FORCES?			30. SOCIAL SECURITY NO.			31. INFORMANT		
No			218 36 2450			Dorothy F. Morgan Mechanicsville, Md.		
32. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								33. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a)								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.								
(b)								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
34. DATE OF OPERATION			35. CONDITION FOR WHICH OPERATION WAS PERFORMED?				36. AUTOPSY?	
							YES <input type="checkbox"/> NO <input type="checkbox"/>	
37. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			38. TIME OF INJURY		39. HOW INJURY OCCURRED		40. ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2	
			HOUR A.M. MONTH DAY YEAR					
41. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			42. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		43. LOCATION		44. CITY OR TOWN	
					STREET		COUNTY STATE	
45. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
46. ACTUAL SIGNATURE			47. TITLE (SPECIFY)			48. MEDICAL EXAMINER		
William D. Boyd II, M.D.			DPT			DATE SIGNED 9/20/85		
49. EXAMINER'S NAME (TYPE OR PRINT)			50. ADDRESS			51. BALTIMORE CITY OR COUNTY OF DEATH		
William D. Boyd II, M.D.			Leonardtown, Maryland			Charlotte Hall, Maryland		
52. BURIAL, CREMATION, REMOVAL (SPECIFY)			53. DATE		54. NAME OF CEMETERY OR CREMATORY		55. LOCATION	
Burial			Sept. 25, 1985		All Faith Cem.		Charlotte Hall, Maryland	
56. FUNERAL DIRECTOR			57. DATE REC'D. BY REGISTRAR			58. REGISTRAR'S SIGNATURE		
W. Clarke Mattingley			SEP 24 1985			Sickie Davidson-Randall		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 3 OF YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

2000s

260071

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 5 2 6 6 5 9

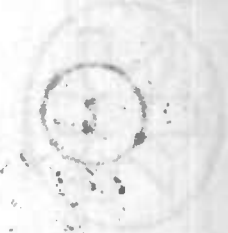
1- FOR
STATE
REGISTRAR

1. DECEASED NAME FIRST MIDDLE LAST John Henry Morgan			2a. DATE OF DEATH MONTH DAY YEAR 9 06 85		2b. HOUR 2335 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 09 18 09	6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH St Mary's County MD.		
10. CITY OR TOWN OF DEATH Leonardtown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY St. Mary's		
13c. CITY OR TOWN Mechanicsville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS / ZIP CODE Rt 3 box 280 / 20659			14. FATHER'S NAME FIRST MIDDLE LAST George Henry Morgan		
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Ann Goldsborough			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		
16b. SOCIAL SECURITY NO. 214-18-8146			17. INFORMANT ADDRESS Mary D. Morgan Mechanicsville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Diffuse Metastases					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months
DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma of Colon					1+ years
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Chronic Congestive Heart Failure					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from Sept 84 to Sept 85 that (2) (we) lost saw the deceased alive on 3 Sept 85 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)		22b. SIGNATURE John W. Porche, MD			
22c. PHYSICIAN'S NAME (TYPE OR PRINT) John W. Porche, MD		22d. ADDRESS PO Box 186, Mechanicsville, Maryland 20659		22e. DATE SIGNED 6 Sept 85	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 9, 1985		23c. NAME OF CEMETERY OR CREMATORY St Joseph	
23d. LOCATION CITY OR TOWN COUNTY STATE Morganza, St Mary's, Md.		24. FUNERAL DIRECTOR ADDRESS W. Clarke Mattingley Leonardtown, Maryland			
25a. DATE REC'D. BY REGISTRAR SEP 11 1985		25b. REGISTRAR'S SIGNATURE W. Clarke Mattingley			

170038

RECEIVED

WILLIAM



07/B4
25M

DHMH - 17
(VR A) 5 ME (5))

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF AN AUTOPSY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR
FOR YOUR FILES. RETURN PAGES 4 AND 5 TO THE MEDICAL EXAMINER ALONG WITH FORM 100-2. RETURN PAGES 6 AND 7 TO THE MEDICAL
DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED TO THE MEDICAL EXAMINER WITHIN 72 HOURS
AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF CRIMINAL INVESTIGATION, 100 WESTON STREET, WASHINGTON, D.C. 20540.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										26660 REG. NO.	
DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH				2b. HOUR	
William Henry Neale						DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Sept. 7, 85				7 AM	
1. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD				2d. HOUR	
Male	Black	May 26, 1936	49 YRS.	MONTHS	DAYS	Sept. 7, 85				MD	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Md.		USA				St. Mary's					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Clements			Home								
13a. STATE					13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS	
Md.					St. Mary's	Clements	YES			P.O. Box 23 20624	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
Clarence Thomas Neale, Sr.					Nellie Gertrude Curtis						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS	
Yes					1958-1964		217-32-1882			P.O. Box 16	
					Veronica Carter, Clements, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden Death - Prob. Cardiac Arrest</u> Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 10.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <u>David C. Allen</u>			TITLE (SPECIFY) <u>M.D. Army Deputy</u> MEDICAL EXAMINER								DATE SIGNED <u>9/9/85</u>
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS								
David C. Allen, M.D.			Leonardtown, Md. 20650								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN		COUNTY	STATE	
Burial		9/11/85		Cheltenham V.A.Cem.			Cheltenham, P.G.			Md.	
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
W. Clarke Mattingley, Leonardtown, Md.						SEP 11 1985		<u>Julia Davidson</u>			

SEP 11 1985



282013

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		5 2 6 6 6 1	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST EDITH	MIDDLE EMMA	MONTH SEPTEMBER	DAY 27, 1985
LAST ROBERTS		2b. HOUR 12 ⁰¹ AM	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH	
MONTH JAN.		DAY 31, 1916	
YEAR 1916		6. AGE (IN YEARS LAST BIRTHDAY)	
69		YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GEORGIA		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S MD.	
10. CITY OR TOWN OF DEATH LEONARDTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CEDAR LANE APTS., #409	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY ST. MARY'S	
13c. CITY OR TOWN LEONARDTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS CEDAR LANE APTS., #409		20650	
14. FATHER'S NAME FIRST J. MIDDLE T. LAST GOARE		15. MOTHER'S MAIDEN NAME FIRST STELLA MIDDLE LAST BRIGHTWELL	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 403-05-1301D	
17. INFORMANT 301 Green Acre Lane RUTH SCHNELLER, California, Maryland 20619		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11-29</u> , 19 <u>83</u> , to <u>9-4</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE JAMES C. BOYD, M.D.		22c. DATE SIGNED 9/30/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 17 JEFFERSON ST., LEONARDTOWN, MD. 20650	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/1/85	
23c. NAME OF CEMETERY OR CREMATORY EVERGREEN MEMORIAL		23d. LOCATION CITY OR TOWN CALIFORNIA, ST. MARY'S, MD.	
24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.		25a. DATE REC'D. BY REGISTRAR OCT 7 1985	
25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

325013

CHIEFLIN



4/30/62

260070

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELEANOR LOUISE SMITH			2a. DATE OF DEATH MONTH DAY YEAR September 6, 1985			2b. HOUR 7:55 PM		
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR 4 22 25		
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		
10. CITY OR TOWN OF DEATH Leonardtwn			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital			9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland			13b. COUNTY St Mary's			13c. CITY OR TOWN Mechanicsville		
14. FATHER'S NAME FIRST MIDDLE LAST John F. Tucker			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EM Inez unknown			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 267 22 2373			17. INFORMANT ADDRESS Rt 2, Box 135 June A. Flickinger Mechanicsville, Md		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cushing's Disease with Steroid Therapy, osteoporosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>severe hypophoria + Chronic Lung Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Hypertension</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>9/85</u> 19 <u>85</u> to <u>9/7/85</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>9/5/85</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>[Signature]</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/7/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James C. Boyd, M. D.						22e. ADDRESS Leonardtwn, Maryland 20650		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept. 10, 1985			23c. NAME OF CEMETERY OR CREMATORY Gardens		
23d. LOCATION CITY OR TOWN COUNTY STATE Leonardtwn, St Mary's, Md.			23e. NAME OF CEMETERY OR CREMATORY Charles Memorial			23f. LOCATION CITY OR TOWN COUNTY STATE Leonardtwn, St Mary's, Md.		
24. FUNERAL DIRECTOR NAME ADDRESS W. Clarke Mattingley Leonardtown, Maryland						25. REGISTRAR'S SIGNATURE REC'D. BY REGISTRAR SEP 11 1985 <i>[Signature]</i>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

300079

THE JAMES EARL RAY CASE
JAMES EARL RAY
September 6, 1968
7:22P

James Earl Ray
60
52
52
St. Mary's County

St. Mary's Hospital



20100

James E. Ray, M.D.
Baltimore, Virginia 20850

270071

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENAL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 6 6 6 3
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Michael Joseph Solski			2a. DATE OF DEATH KNOWN ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 9 14 19 85			2b. HOUR M 2:30P		
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR AUG. 28, 1982	6. AGE (IN YEARS) LAST BIRTHDAY 3 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 16 19 85	7d. HOUR M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CALIFORNIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County, MD.		
10. CITY OR TOWN OF DEATH Lexington Park		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Esperanza Pond				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND			13b. CITY ST. MARY'S		13c. CITY OR TOWN LEXINGTON PARK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 316 PATUXENT VIEW DRIVE 20653			14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH EDWARD SOLSKI			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JULIE JEANNE DUQUETTE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NONE		17. INFORMANT 316 PATUXENT VIEW DRIVE JOSEPH E. SOLSKI, LEXINGTON PARK, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> 9/10/85 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR MONTH DAY YEAR 1+ P.M. 9 14 19 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject drowned			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) pond		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Esperanza Pond, Lexington Park, St. Mary's, MD			
22. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>			TITLE (SPECIFY) Assistant MEDICAL EXAMINER				DATE SIGNED 9/17/85	
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.			ADDRESS 111 Penn St. Balto. MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 9/19/85		23c. NAME OF CEMETERY OR CREMATORY HUNT CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE WALDORF, CHARLES, MARYLAND	
24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.			ADDRESS		25a. DATE REC'D. BY REGISTRAR SEP 20 1985		25b. REGISTRAR'S SIGNATURE <i>John E. Smith</i>	

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275064

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) BRENDA JEAN SYDNOR			2a. DATE OF DEATH MONTH DAY YEAR Sept 27, 1985		2b. HOUR 8:00 P ^M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 6-24-64		6. AGE (IN YEARS LAST BIRTHDAY) 21 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD.	
10. CITY OR TOWN OF DEATH Mechanicsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) at home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STUDENT		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY St. Mary's	13c. CITY OR TOWN Mechanicsville	
14. FATHER'S NAME FIRST MIDDLE LAST Raymond Wesley Sydnor			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Theodora Lorraine Hill		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-98-3023		17. INFORMANT ADDRESS Raymond & Lorraine Sydnor Rt. 1 Box 113 Md. Mechanicsville	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diffuse Metastatic Malignant Melanoma DUE TO, OR AS A CONSEQUENCE OF (b) Malignant Melanoma, Lent III Refractory DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months 6 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that I (this hospital) attended the deceased from 21 Aug 79 to 27 Sept 85, that I (we) last saw the deceased alive on 23 Sept 85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I/we did not view the body after death).					
27b. SIGNATURE John W. Roache, M.D.		DEGREE		27c. DATE SIGNED 27 Sept 85	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) John W. Roache, M.D.		27e. ADDRESS Mechanicsville, Md, 20659			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Sept. 30, 1985	23c. NAME OF CEMETERY OR CREMATORY Queen of Peace		23d. LOCATION CITY OR TOWN COUNTY STATE Helen, St Mary's, Md.	
24. FUNERAL DIRECTOR NAME W. Clarke Mattingley Leonardtown, Maryland		25a. DATE REC'D. BY REGISTRAR SEP 30 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

MEDICAL CERTIFICATION

279

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cards, papers, Page 1 and 2, and file with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



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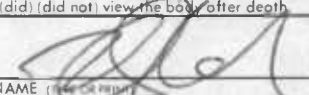
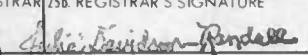
11-2-63

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

282012

DECEASED NAME (TYPE OF PRINT) ZELIA VIRGINIA WELLS		2a. DATE OF DEATH MONTH DAY YEAR September 30, 1985		2b. HOUR 10:20AM	
3 SEX FEMALE	4 RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR MARCH 21, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TEXAS	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH St. Mary's County MD.	
10. CITY OR TOWN OF DEATH Leonardtown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Mary's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EXECUTIVE SECRETARY		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND		13b. COUNTY ST. MARY'S	13c. CITY OR TOWN CALIFORNIA	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JONATHAN JASPER FUGUA		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ZELIA HAMILTON TORREY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 085-07-2913		17. INFORMANT ADDRESS MRS. JOAN COLEMAN, 222 Elmbrook Drive, California, Md. 20619	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure. DUE TO, OR AS A CONSEQUENCE OF (b) Acute Exacerbation of COPD DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Congestive Heart Failure, coronary artery Disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE 		DEGREE		22c. DATE SIGNED 9/30/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) N. Shah, M.D.		22e. ADDRESS Leonardtown, Md. 20650			
23a. BURIAL, CREMATION, REMOVAL CREMATION		23b. DATE 10/1/85		23c. NAME OF CEMETERY OR CREMATORY HUNTT CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE WALDORF, CHARLES, MARYLAND		25a. DATE REC'D. BY REGISTRAR OCT 7 1985			
24. FUNERAL DIRECTOR NAME ADDRESS EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.		25b. REGISTRAR'S SIGNATURE 			

382012

September 30, 1982 10:30

MEMORANDUM FOR THE DIRECTOR

U.S. Navy's Command

Subject: [Illegible]



U.S. Navy's Command

U.S. Navy's Command

276024

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. (ENCLAVES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										26666 REG. NO.	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST THOMAS GEORGE WHEELER							2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR SEPT. 24 19 85		2b. HOUR 1107 a.m.		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MARCH 16, 1942		6. AGE (IN YEARS) LAST BIRTHDAY 43 YRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR SEPT. 24 19 85		2d. HOUR 2:00p.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA				7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ST. MARY'S MD		
10. CITY OR TOWN OF DEATH PATUXENT RIVER				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY ELECTRONICS	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MARYLAND		13b. COUNTY ST. MARY'S		13c. CITY OR TOWN CALIFORNIA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 603 JOAN DRIVE		20619	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE EARNEST WHEELER						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IRMA HOELZEN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. 1967-1969		17. INFORMANT ADDRESS 603 JOAN DRIVE BERIT B. WHEELER, CALIFORNIA, MD. 20619					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sec	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>William D. Boyd, II</u>				TITLE (SPECIFY) M.D. <u>Dr. Boyd</u>				DATE SIGNED <u>9/27/85</u>			
EXAMINER'S NAME (TYPE OR PRINT) WILLIAM D. BOYD, II, M.D.				ADDRESS 17 JEFFERSON ST., LEONARDTOWN, MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION				23b. DATE 9/26/85		23c. NAME OF CEMETERY OR CREMATORY HUNT CEMETORY		23d. LOCATION CITY OR TOWN COUNTY STATE WALDORF, CHARLES, MARYLAND			
24. FUNERAL DIRECTOR NAME EDWARD N. BRINSFIELD, JR., LEONARDTOWN, MD.						25a. DATE REC'D. BY REGISTRAR SEP 30 1985		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson</u>			

MEDICAL CERTIFICATION

100-100000

TO: THE SECRETARY OF THE ARMY
FROM: THE SECRETARY OF THE ARMY
SUBJECT: [Illegible]

[Illegible handwritten text]